

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049273

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12328

STATE FILE NUMBER

FILED DEC 20 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS	
St. Louis, Mo. St. Louis City Hosp. # 1		Mo. St. Louis 5011 Delmar	
3. NAME OF DECEASED (Type or print) First Middle Last Glen Bost		4. DATE OF DEATH Month Day Year 12 12 63	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-10-93
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		9b. KIND OF BUSINESS OR INDUSTRY Painting	9c. AGE (last birthday) 70
10a. BIRTHPLACE (City and state or country) Fillmore, Ill.		10b. CITIZEN OF WHAT COUNTRY U.S.A.	
11a. FATHER'S NAME Eliss Bost		11b. MOTHER'S MAIDEN NAME Gacy Mason	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no		12b. SOCIAL SECURITY NO. [REDACTED]	
13a. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CEREBRAL ARTERY THROMBOSIS, LAENECC'S CIRRHOSIS		13b. NAME OF HUSBAND OR WIFE XNER (Divorced) 422 S. Poplar Centralia, Illinois	
14. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
16. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		17. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 491X	
18. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		19. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 491X	
20. CITY, TOWN, OR LOCATION COUNTY STATE		21. I attended the deceased from 10-23-63 to 12-12-63 and last saw her/him alive on 12-12-63 Death occurred at 9:00p m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Daniel K. Bach, M.D.		22b. ADDRESS 1515 Lafayette Ave.	
22c. DATE SIGNED 12-12-63		23. NAME OF CEMETERY OR CREMATORY Glendale Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-15-63	
23c. LOCATION (City, town, or county) Fillmore, Illinois		23d. (State)	
24. FUNERAL DIRECTOR Allen F. Home		25. DATE RECD. BY LOCAL REG. DEC 13 1963	
26. ADDRESS Fillmore, Ill.		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ronald W. Larkin

Licensed Embalmer No. 5197

P. O. Address E. St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.